## Feb. 24. 2011 8:53AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 0780 P. 7 PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155760	B. Wi	NG		1	-C 5/2011
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				1	REET ADDRESS, CITY, STATE, ZIP CODE 332 WATERFORD CIRCLE SOSHEN, IN 46525		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 000}	to the investigation IN00084191 compl Complaint #IN0008	ne Post Survey Revisit (PSR) of Complaint Number leted on 1/7/11. 84191: Corrected	(FC	000)	RECEIVI	ED	
- }	Unrelated findings Survey Dates: 2/14				FEB 2 8 20	1	
	Facility number: 01 Provider number: 1 Aim number: 2008:	55760			LONG TERM CARE DIVI INDIANA STATE DEPARTMENT	SION OF HEALTH	
	Survey Team: Ellen Ruppel, RN  Census bed type: SNF: 24 SNF/NF: 41 Total: 65						
арр 312111 Вт	Census payor type Medicare: 24 Medicaid: 18 Other: 23 Total: 65	:					
,	Sample: 6						
	accordance with 4'		i				
SS=G	PERSONS/PER C	N RVICES BY QUALIFIED ARE PLAN		282		;	
ABORATOR	Y DIRECTOR'S OR PROVI	DEPSUPPLIER REPRESENTATIVE'S SIG	NATUR <b>P</b>	N	inestrator	2/0	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

No. 0780 P. 8 PRINTED: 02/18/2011 FORM APPROVED

OMB NO. 0938-0391

155760 B. WING R-C 02/15/2011	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155760		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS    Tag						I .		
F 282 Continued From page 1 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility falled to follow physician's orders for 1 of 6 residents whose records were reviewed for accuracy of medications. This deficit practice resulted in the resident receiving two types of incorded medications (insulin and eye medication) and the omission of two additional medications (lood thinner and appetite stimulant.) The resident sustained a hypoglycemic reaction, resulting in a fall and required emergency from treatment. Resident B  Findings Include:  1. During the orientation tour, on 2/14/11 at 9:00 a.m., the Director of Nursing (DoN) identified Resident B as being a recent admission to the facility and having had a fall in the sarly morning hours of 2/14/11. The resident was observed to have abrasions on the forehead and both sides of his face. The right eye was beginning to turn dark in color.  The clinical record of Resident B was reviewed, on 2/14/11 at 10:50 a.m., and indicated the esident had been admitted to the facility on 2/7/11, from the Veterars's Administration Healthcare System (VA). His diagnoses included.	NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				13	332 WATERFORD CIRCLE		
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility falled to follow physician's orders for 1 of 6 residents whose records were reviewed for accuracy of medications. This deficit prectice resulted in the resident receiving two types of incorrect medications (insulin and eye medication) and the omission of two additional medications (blood thinner and appetite stimulant). The resident sustained a hypoglycemic reaction, resulting in a fall and required emergency room treatment. Resident B Findings Include:  1. During the orientation tour, on 2/14/11 at 9:00 a.m., the Director of Nursing (DoN) identified Resident B as being a recent admission to the facility and having had a fall in the early morning hours of 2/14/11. The resident was observed to have abrasions on the forherdeal and both sides of his face. The right eye was beginning to turn dark in color.  The clinical record of Resident B was reviewed, on 2/14/11 at 10:50 a.m., and indicated the resident had been admitted to the facility on 2/7/11, from the Veteran's Administration 12/7/11, from the Veteran's Administration 2/7/11, like diagnoses included, the like and the province of the called the resident had been admitted to the facility on 2/7/11, from the Veteran's Administration 2/7/11, like diagnoses included, the like and the province of the called the resident had been admitted to the facility on 2/7/11, from the Veteran's Administration 2/7/11, like diagnoses included, the like and the province of the called the resident had been admitted to the facility on 2/7/11, from the Veteran's Administration 2/7/1	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	ULD BE COMPLETION	
back pain, glaucoma and urinary tract infection.	F 282	The services provided to accordance with excert.  This REQUIREME by: Based on observative review, the facility orders for 1 of 6 reviewed for accurdeficit practice restwo types of incorreye medications (blood stimulant.) The rehypoglycemic reactive emergence of the provided eme	ded or arranged by the facility by qualified persons in each resident's written plan of the resident's written plan of the resident's written plan of the resident's written plan of falled to follow physician's elidents whose records were eacy of medications. This uited in the resident receiving eact medications (insulin and did the omission of two additional hinner and appetite elident sustained a tion, resulting in a fall and ey room treatment. Resident Be that a fall in the early morning the resident was observed to the forehead and both sides of eye was beginning to turn dark of Resident B was reviewed, the forehead and both sides of eye was beginning to turn dark of Resident B was reviewed, the forehead and both sides of eye was beginning to turn dark of Resident B was reviewed, the forehead and both sides of eye was beginning to turn dark of Resident B was reviewed, the facility on eleran's Administration of (VA). His diagnoses included, do: diabetes, hypertension,		282	with the attending phsyicist during the time of survey resident's eye drops, Megastovenox orders were clarificating the time of survey. Lovenox orders were clarificating the time of survey. 2: All admission charts sixthe original date of compl. 2/6/11, were audited for acorder transcription on admorders needing clarificating addressed and clarified with attending physician during of survey.  3: All licensed nurses were serviced on order transcription on including of survey. It is a serviced on order transcription on the different insulin including onset, produced on the different insulin including onset, produced on the guidelimanaging hypoglycemia and hyperglycemia. An insulin chart has been placed in expressions.	iffied an . The ce and ied an . The ce and ied an . The curacy of ission and on were the the time the time the time re inption and orders. All rviced on clarify swere intypes of leak, sees were nes for reference each MAR for	

No. 0780 P. 9 PRINTED: 02/18/2011 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING_	¥	R-C 02/15/2011		
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  1332 WATERFORD CIRCLE  GOSHEN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAĞ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION	
	"INSULIN, ASPAR INJECT 12 UNITS DAILY BEFORE M transcribed as "Hu (subcutarieous) timeais." The Aspan onset in 15 min and 3-5 hours during which is Regular in hour, and a peak in 8-12 hours. The insulin. This inforfact sheet provided DoN, on 2/14/11 at The order also ince HUMAN 100 UNIT UNDER SKIN AT OTHER INSULING transcribed as "Hu milliliter) 45 u (unit sleep)." The Glar with an onset of 1. hours duration. The admission order in and the order had acting insulin. This from a fact sheet pand DoN, on 2/14/1 The admission order in SULIN, HUMAI 180-200 4U (4 ur 251-300 8U, 301 (sliding scale) QID meals) GREATER (medical doctor)."	lers from the VA included: IT, HUMAN 100 UNIT/ML INJ I UNDER SKIN THREE TIMES IEALS." This order had been Iman 100u/ml 12 U subq Id (three times daily) (before) In action. The Human is Novolin Insulin with 1 to 2 hours peak Intion. The Human is Novolin Insulin with an onset of 0.5 -1 In 2.5-5 hours and duration of Iduman was the wrong type of Iman was obtained from a Id by the corporate nurse and It 1:30 p.m. Inded "INSULIN, GLARGINE, IMIC INJ (INJECT) 45 UNITS INJ (INJECT) 45 UN	F 282	4: Admission orders will be and verified with the atter physician on admission. A nurse will verify accuracy and transcription to the Madmission. Neither one of nurses will be the DHS. The or designee will perform an audit of a admission charts for compland accuracy of transcript admission orders within 24 and make a notation of revente admission checklist. The or designee will ensure that any order clarification are clarification are clarification are clarification of admission orders and with notation of review on the checklist. The unit manager review all new orders in material and clarify any or that time with the attending the time with the attending and clarify any or that time with the attending and clarify any or that time with the attending and clarify any or that time with the attending and clarify any or that time with the attending and clarify any or that time with the attending are review all new orders. The DHS will perform a random audit weekly of maccuracy of orders. The DHS report monthly to the QA&A on outcomes of the audits	ending second of orders MAR on these he DHS  all leteness tion of hours view on The DHS  as needing ed. The admission hd accuracy ill make a admission ers will morning these at ing physician. cify correct of review or designee hew orders and DHS will A Committee	

No. 0780 P. 10 PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S COMPLE	TED
		155760	B. WING		l l	8-C 5/2011
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS		13	EET ADDRESS, CITY, STATE, ZIP ( 332 WATERFORD CIRCLE IOSHEN, IN 46526	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE
F 282	any of the 7 days had received no of 180. Twelve time indicated the blood parameter for condition of the con	ot received the correct insulin for he had been in the facility and coverage for blood sugars above as the glucometer checks of sugar was above the verage.  e insulin in the medication cart, 00 a.m., indicated only one vialident B. It was Humulin R 100 label indicated, " use 12 units lay with meals and 45 units." The nurse (LPN #4) giving tesident B's hall was queried on 2/14/11 at 11:10 a.m., and res the only one used for him.  Inical record for Resident B, on a.m., indicated the night nurse he nurse's notes at 12:10 a.m., and responding to verbal or B/P (blood pressure) 130/76, Pespirations) 18. res has head, nose, and both (upper)	F 282	committee. The DHS is for substantial compl	responsible	
	cheek bones, ble sugar) @ (at) 23. 911 EMT (emerg called. Res remains 0030 (12:30 a.m., given by EMTs. to answer simple response. attemback in bed. Which Res. verbalized beack. EMT's plain from building to (unit manager not	eding minimally-Res BS (blood Glucagon injection given and ency medical technicians) ains unresponsive. BS @ 24.  ) EMT'S arrive, more glucose Res after 5 mins (minutes) able questions, often with wrong pted c (with) EMT, to put res ile attempting to set res upright, arge amt (amount) of pain in ced on gurney and removed res. local hospital), family, Dr and iffied. Will inform Dr of Res need c (with) BS (blood sugar) and				

No. 0780 P. 11 PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDI		j F	R-C	
<del></del>		155760	B. WING		02/1	<u>5/2</u> 011
NAME OF PROVIDER OR SUPPLIER  MAPLES AT WATERFORD CROSSING HEALTH CAMPUS		ROSSING HEALTH CAMPUS		REET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIRCLE GOSHEN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 282	Continued From pa insulin."	ge 4	F 28	2		
	fractures. Residen facility, on 2//14/11 insulin to 8 units at bedtime. Orders for times daily for wounds three times were sent by the horder to be physician was administration, on a correction to Lantus 8 units at mealtime	notified of the errors in insulin 2/14/11 and ordered the s 45 units at bedtime, Novolog and coverage with Humulin R ally ordered at the time of				
	type of insulin and	reived 22 doses of the wrong missed 12 coverage doses, om his admission on 2/7 to				
	included an order for (Cosopt) opth sol (cosopt) opth sol (doth eyes) bid (twing transcribed as "Time drop in both eyes to received the wrong	orders for Resident B also or "drozolamide 2/timolol 0.5% ophthalmic solution) 1 drop ou ce daily)." This order had been tolol 0.5% (timoptic) instill 1 BID." The resident had eye drops for 7 days. Cosopt glaucoma eye disease.				
	cart, on 2/15/11 at	eye drops in the medication 8:00 a.m., indicated the only dent B were Timoptic.		:		
	an order for "ENOX	orders for Resident B included (APARIN INJ 30 MG/ 0.3 ML This order had not been				

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PLIER  RD CROSSING HEALTH CAMPUS  RY STATEMENT OF DEFICIENCIES (GIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)  om page 5  nd the resident had not received a of the injectable blood thinner.  1 admission orders for Resident B an order for "MEGESTROL TAB 4 y) BID." This order had not been not the resident had not received a	A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP 1332 WATERFORD CIRCLE GOSHEN, IN 46526  PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO TO DEFICIENC	CORRECTION (X5) ION SHOULD SE COMPLETION THE APPROPRIATE DATE
RD CROSSING HEALTH CAMPUS  RY STATEMENT OF DEFICIENCIES (CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)  om page 5  Ind the resident had not received a of the injectable blood thinner.  I admission orders for Resident B an order for "MEGESTROL TAB and the page of the page o	1332 WATERFORD CIRCLE GOSHEN, IN 46526  ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC  F 282	CORRECTION (X5) ION SHOULD BE COMPLETION THE APPROPRIATE DATE
ICIENCY MUST BE PRECEDED BY FULL ITY OR LSC IDENTIFYING INFORMATION)  om page 5  nd the resident had not received a of the injectable blood thinner.  I admission orders for Resident B an order for "MEGESTROL TAB y) BID." This order had not been	PREFIX TAG CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE COMPLETION THE APPROPRIATE DATE
nd the resident had not received a of the injectable blood thinner. I admission orders for Resident B an order for "MEGESTROL TAB y) BID." This order had not been	1 1 1	
appetite stimulator.		sulin and 2 128/11
RESIDENTS FREE OF T MED ERRORS ust ensure that residents are free it medication errors.	accucheck orders were	e clarified  hysician during  The resident's
(blood thinner and appetite he resident sustained a creaction, resulting in a fall and	the original date of 2/6/11, were audited of order transcription and orders needing continuous addressed and continuous time of survey. All of reviewed for accuracy	time of survey.  ts since  compliance,  for accuracy on on admission  larification  larified with  ian during the  diabetics were  y of their  k orders and  ng the attending
	lications (insulin and eye and the omission of two additional blood thinner and appetite the resident sustained a reaction, resulting in a fall and regency room treatment. Resident E	the attending physic time of survey. All reviewed for accuracy room treatment. Resident B  the attending physic time of survey. All reviewed for accuracy insulin and accuched parameters for calli

No. 0780 P. 13 PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  MAPLES AT WATERFORD CROSSING HEALTH CAMPUS  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS  (EACH CORRETTIVE ACTION SHOULD BE COMPLET TO CENTURE ACTION SHOULD BE CACH CORRETTIVE ACTION SHOULD BE CACH CORNETTIVE ACTION SHOULD BE CACH CORRETTIVE ACTION SHOULD BE CACH CORNETTIVE ACTION SHOUL	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  MAPLES AT WATERFORD CROSSING HEALTH CAMPUS  (X4) ID  PREFIX TAG  CONTINUED From page 6  1. During the orientation tour, on 2/14/11 at 9:00  a.m., the Director of Nursing (DoN) identified Resident B as being a recent admission to the facility and having had a fall in the early morning hours of 2/14/11. The resident was observed to have abrasions on the forehead and both sides of his face. The right eye was beginning to turn dark in color.  The clinical record of Resident B was reviewed, on 2/14/11 at 10:50 a.m., and indicated the resident had been admitted to the facility on 2/7/11, from the Veteran's Administration Healthcare System (VA). His diagnoses included, but were not limited to: diabetes, hypertension, back pain, glaucoma and urinary tract infection.  STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIRCLE GOSHEN, IN 46526  BY REFIX TAG  STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIRCLE GOSHEN, IN 46526  GOSHEN, IN 46526  F 333 All licensed nurses were in-serviced on order transcription and how to complete admission orders. All licensed nurses were in-serviced on the different types of insulin including on sent, peak, duration. All licensed nurses were in-serviced on the guidelines for managing hypoglycemia and hyperglycemia. An insulin reference chart has been placed in each MAR for reference by the licensed nurses. All licensed nurses were in-serviced on the guidelines for managing hypoglycemia and hyperglycemia. An insulin reference chart has been placed in each MAR for reference by the licensed nurses were in-serviced on completing and documenting on the diabetic flow sheet for all resident receiving accuchecks				A. BUILDIN	G	P-C
Summary Statement of Deficiencies   Summary Statement of Deficiencies   Summary Statement of Deficiencies   Summary Statement of Deficiency			155760	B. WING _		1
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF F	ROVIDER OR SUPPLIER			• •	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 333  Continued From page 6  1. During the orientation tour, on 2/14/11 at 9:00 a.m., the Director of Nursing (DoN) identified Resident B as being a recent admission to the facility and having had a fell in the early morning hours of 2/14/11. The resident was observed to have abrasions on the forehead and both sides of his face. The right eye was beginning to turn dark in color.  The clinical record of Resident B was reviewed, on 2/14/11 at 10:50 a.m., and indicated the resident had been admitted to the facility on 2/71/11, from the Veteran's Administration Healthcare System (VA). His diagnoses included, but were not limited to: diabetes, hypertension, back pain, glaucoma and urinary tract infection.	MAPLES	AT WATERFORD C	ROSSING HEALTH CAMPUS			
1. During the orientation tour, on 2/14/11 at 9:00 a.m., the Director of Nursing (DoN) identified Resident B as being a recent admission to the facility and having had a fall in the early morning hours of 2/14/11. The resident was observed to have abrasions on the forehead and both sides of his face. The right eye was beginning to turn dark in color.  The clinical record of Resident B was reviewed, on 2/14/11 at 10:50 a.m., and indicated the resident had been admitted to the facility on 2/7/11, from the Veteran's Administration Healthcare System (VA). His diagnoses included, but were not limited to: diabetes, hypertension, back pain, glaucoma and urinary tract infection.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE COMPLETION
"INSULIN, ASPART, HUMAN 100 UNIT/ML INJ INJECT 12 UNITS UNDER SKIN THREE TIMES DAILY BEFORE MEALS." This order had been transcribed as "Human 100u/ml 12 U subq (subcutaneous) tid (three times daily) (before) meals." The Aspart insulin is Novolog which has an onset in 15 minutes, with 1 to 2 hours peak and 3-5 hours duration. The Human is Novolin which is Regular insulin with an onset of 0.5-1 hour, and a peak in 2.5-5 hours and duration of 8-12 hours. The Human was the wrong type of insulin. This information was obtained from a fact sheet provided by the corporate nurse and DoN, on 2/14/11 at 1:30 p.m  The order also included "INSULIN, GŁARGINE, HUMAN 100 UNIT/ML INJ (INJECT) 45 UNITS UNDER SKIN AT BEDTIME DO NOT MIX WITH OTHER INSULINS" This order had been transcribed as "Human R 100u/ml (100 units per milliliter) 45 u (units) subq (every) hs (hour of	F 333	1. During the oriel a.m., the Director Resident B as beir facility and having hours of 2/14/11. have abrasions on his face. The right in color.  The clinical record on 2/14/11 at 10:5 resident had been 2/7/11, from the V Healthcare System but were not limite back pain, glaucor The admission or "INSULIN, ASPAFINJECT 12 UNITS DAILY BEFORE M transcribed as "Hu (subcutaneous) timeals." The Asp an onset in 15 mir and 3-5 hours dur which is Regular in hour, and a peak 8-12 hours. The insulin. This infor sheet provided by on 2/14/11 at 1:30.  The order also inc HUMAN 100 UNIT UNDER SKIN AT OTHER INSULING transcribed as "Hit t	ntation tour, on 2/14/11 at 9:00 of Nursing (DoN) identified ing a recent admission to the had a fall in the early morning. The resident was observed to the forehead and both sides of the teye was beginning to turn dark of Resident B was reviewed, of a.m., and indicated the admitted to the facility on eteran's Administration (VA). His diagnoses included, doto: diabetes, hypertension, malers from the VA included: RT, HUMAN 100 UNIT/ML INJUNDER SKIN THREE TIMES (MEALS." This order had been uman 100u/ml 12 U subquit (three times daily) (before) art insulin is Novolog which has nutes, with 1 to 2 hours peak ation. The Human is Novolin insulin with an onset of 0.5 -1 in 2.5-5 hours and duration of Human was the wrong type of mation was obtained from a fact the corporate nurse and DoN, p.m	F 333	in-serviced on order trans and how to complete admiss All licensed nurses were i on the different types of including on sent, peak, de All licensed nurses were in on the guidelines for manate hypoglycemia and hyperglycemia and hyperglycemia and hyperglycemia insuling reference chart has placed in each MAR for reference to by the licensed nurses. All nurses were in-serviced on and documenting on the dial sheet for all resident reconstruction accuchecks  4: Admission orders will be well and verified with the attending physician on admission. A secon nurse will verify accuracy of and transcription to the MAR condission. Neither one of these nurses will be the DHS. The DH designee will perform an audit of all admission within 24 hours and make a not of review on the admission charts for completeness and according clarification are clared the DHS or designee will ensure any orders needing clarification are clared the Director of Clinical Services will audit weekly the admission completeness and accuracy of and will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land will make a notation of reference and accuracy of a land	scription sion orders. n-serviced insulin duration. n-serviced aging semia. An as been serence all licensed a completing abetic flow seiving sitten ag orders on see assor sion scuracy orders station ecklist. re that rified. ices on charts for admission orders

Event ID: 85U212

No. 0780 P. 14 PRINTED: UZ/18/2011

FORM APPROVED OMB NO. 0938-0391

I 155760  8. WING OF PROMDER OR SUPPLER  MAPLES AT WATERPORD CROSSING HEALTH CAMPUS  SUMMANY STATEMENT OF DEFICIENCIES OF STREAM (EACH DEFINE WAS 18 PRESENCED TO THE APPROPRIATE DEFICIENCY WAS 18 PRESENCED TO THE APPROPRIATE DEFICIENCY MAY 18 SUPPLIES OF STREAM WATERPORD CROSS REPRENENCED TO THE APPROPRIATE DEFICIENCY TAG TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAG TO THE APPROPRIATE DEFICIENCY THE APPROPRIATE DEFICIENCY TO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
NAME OF PROVIDER OR SUPPLER  MAPLES AT WATERFORD CROSSING HEALTH CAMPUS    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIST GUENTHAM INFORMATION)   TAG    FRETTY REGULATORY OR LIST GUENTHAM INFORMATION)   TAG    FROM CORRECTIVE ACTION SHOULD BE COMMETTION STATE OF COMMETTION SHOULD BE COMMETTING WITH AN OF CORRECTION SHOULD BE COMMETTING WITH AND OF CORRECTION OF CORRECTION OF CORRECTION OF CORRECTION OF CORRECTION OF CORRECTION OF THE SAIL TIME AND OF CORRECTION OF CORRE			ı				
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS  (ACA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  FRESTIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  FROM CORRECTION SHOULD BE CAMPETING INFORMATION)  FRESTIX TAG  Continued From page 7 sleep).* The Glargine insulin is Lantus Insulin with an onest of 1.5 hours, constant peak and 24 hours duration. The Lantus is long acting insulin mand the order had been transcribed for short acting insulin. The Lantus is long acting insulin and the order had been transcribed for short acting insulin. The Lantus is long acting insulin and the corder had been transcribed for short acting insulin. The Lantus is long acting insulin and the order had been transcribed for short acting insulin. The Lantus is long acting insulin and the managers will review all new orders in the morning meeting and clarify any orders at that time with the attending physician. The unit managers will verify correct transcription at the time of review of the new order. The DIBS or designee will perform a random audit weekly of new orders for correct transcription and accuracy of orders. The DIBS or designee will perform a random audit weekly of all residents with insulin coverage to verify accurate and complete documentation of the blood sugars and insulin coverage given in addition to appropriate and timely notification of the physician.  The DIS will report monthly on outcomes of the audits for the next of months of the physician and addition to appropriate and timely notification of the physician. The DIS or designee will perform a random audit weekly of all residents with insulin coverage given in addition to appropriate and timely notification of the physician.  The DIS will report monthly on outcomes of the audits for the next of months of the physician and addition to appropriate and timely notification of the physician.  The DIS is responsible for substantial compliance.			155760	B. WING _		02/1/	5/2011
F333 Continued From page 7  Scoular From Page 7  Sc			ROSSING HEALTH CAMPUS	] -	1332 WATERFORD CIRCLE		
sleep)." The Glargine insulin is Lantus Insulin with an onset of 1.5 hours, constant peak and 24 hours duration. The Lantus is long acting insulin and the order had been transcribed for short acting insulin. This information was obtained from a fact sheet provided by the corporate nurse and DoN, on 2/14/11 at 1:30 p.m.  The admission orders included insulin coverage, "INSULIN, HUMAN REGULAR 100 UNIT/ML INJ 180-200 4U (4 units of insulin), 201-250 6U, 251-300 8U, 301-350 12U, 351-400 18U, 8C (slidling scale) (DID (four times daily) AC (before meals) GREATER THAN 400 UNITS CALL MD (medical doctor). This order had not been transcribed on the medication record.  Resident B had not received the correct insulin for any of the 7 days he had been in the facility and had received no coverage for blood sugars above 180. Twelve times the glucometer checks indicated the blood sugar was above the parameter for coverage.  Observation of the insulin in the medication cart, on 2/14/11 at 11:00 a.m., indicated only one vial of insulin for Resident B. It was Humulin R 100 units/ ml. and the leabel indicated, "use 12 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day with meals and 45 units sub-q 3 times a day to no eused for him.  Review of the clinical record for Resident B, on 2/14/11 at 10:50 a.m., indicated the night nurse had recorded in the nurse's notes at 12:10 a.m., "Res (resident) found lying on floor next to bed on the facility and the facility an	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	
I MARIN FORM MODERN TOURNMENT IN MARINE OF 1	F 333	sleep)." The Glarg with an onset of 1.9 hours duration. The and the order had acting insulin. This from a fact sheet p and DoN, on 2/14/1 The admission ord "INSULIN, HUMAN 180-200 4U (4 un 251-300 8U, 301-(aliding scale) QID meals) GREATER (medical doctor)." transcribed on the Resident B had no any of the 7 days had received no co 180. Twelve times indicated the blood parameter for cover Observation of the on 2/14/11 at 11:00 of insulin for Residunits/ ml. and the lisub-q 3 times a dasub-q at bedtime." medications on Reabout his insulin, on she indicated it was Review of the clinical and recorded in the "Res (resident) for the corded in the "Res (resident) for the side of the clinical and recorded in the "Res (resident) for the clinical and recorded in the "Res (r	gine insulin is Lantus Insulin 5 hours, constant peak and 24 le Lantus is long acting insulin been transcribed for short information was obtained revided by the corporate nurse 11 at 1:30 p.m  ers included insulin coverage, I REGULAR 100 UNT/ML INJits of insulin), 201-250 6U, 350 12U, 351-400 15U, SC (four times daily) AC (before 1 THAN 400 UNITS CALL MD This order had not been medication record.  It received the correct insulin for the had been in the facility and everage for blood sugars above the glucometer checks is sugar was above the grage.  Insulin in the medication cart, 0 a.m., indicated only one vial ent B. It was Humulin R 100 abel indicated, "use 12 units y with meals and 45 units. The nurse (LPN #4) giving isident B's hall was queried in 2/14/11 at 11:10 a.m., and s the only one used for him.  Cal record for Resident B, on .m., indicated the night nurse in urse's notes at 12:10 a.m., and lying on floor next to bed on	F 333	new orders in the morning and clarify any orders at with the attending physici unit managers will verify transcription at the time of the new order. The DHS will perform a random audit ween new orders for correct trained accuracy of orders. The designee will perform a random audit ween residents with insulin converify accurate and completed documentation of the blood and insulin coverage given addition to appropriate and notification of the physical The DHS will report monthly outcomes of the audits for 6 months to the QA&A Commit and thereafter as determined by the QAA commit The DHS is responsible for	meeting that time an. The correct of review or design extly of mescription the DHS or extly of all rerage to the disugars in ind timely rian. y on the next ttee,	ee h

No. 0780 P. 15 PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE	
155760		155760	B. WING		R-C 02/15/2011	
	ROVIDER OR SUPPLIER  AT WATERFORD CF	ROSSING HEALTH CAMPUS	1:	REET ADDRESS, CITY, STATE, ZIP CODI 332 WATERFORD CIRCLE SOSHEN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 333	(pulse) 101, R (res abrasions to forehe cheek bones, bleer sugar) @ (at) 23. 911 EMT (emerger called. Res remain 0030 (12:30 a.m.) given by EMTs. R to answer simple q response. attempt back in bed. While Res. verbalized lar back, EMT's place from building to (lo unit manager notifi	ige 8  P (blood pressure) 130/76, P pirations) 18. res has ead, nose, and both (upper) ding minimally—Res BS (blood Glucagon injection given and ncy medical technicians) ns unresponsive. BS @ 24. EMT'S arrive, more glucose tes after 5 mins (minutes) able uestions, often with wrong ted c (with) EMT, to put res a attempting to set res upright, ge amt (amount) of pain in ed on gurney and removed res. cal hospital)., family, Dr and ed. Will inform Dr of Res need (with) BS (blood sugar) and	F 333			
	fractures. Resider facility, on 2//14/11 insulin to 8 units at bedtime. Orders for times daily for wounds three time were sent by the h			•		
	administration, on correction to Lantu 8 units at mealtime	notified of the errors in insulin 2/14/11 and ordered the is 45 units at bedtime, Novologe and coverage with Humulin R ally ordered at the time of SVA.		:		
	type of insulin and	ceived 22 doses of the wrong missed 12 coverage doses, rom his admission on 2/7 to	•			: : :

Event ID:85U212

Feb. 24. 2011 8:54AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 0780 P. 16 PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A, BUILDING			COMPLETED		
		155760	B. Wil	NG			R-C 15/2011
* * **	OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1232 WATERFORD CIRCLE  GOSHEN, IN 46526						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 333	2. The admission included an order (Cosopt) opth sol (both eyes) bid (the transcribed as "The drop in both eyes received the wrong is a medication of the cart, on 2/15/11 and the doses of the doses of the doses of the doses of the do (orally) Experience and the doses of the dos	n orders for Resident B also for "drozolamide 2/timolol 0.5% (ophthalmic solution) 1 drop ou wice daily)." This order had been imolol 0.5% (timoptic) instill 1 is BID." The resident had ng eye drops for 7 days. Cosopt or glaucoma eye disease. He eye drops in the medication at 8:00 a.m., indicated the only sident B were Timoptic. In orders for Resident B included DXAPARIN INJ 30 MG/ 0.3 ML I." This order had not been he resident had not received any he injectable blood thinner. Imission orders for Resident B order for "MEGESTROL TAB 40 BID." This order had not been he resident had not received any	F	333			
	:			!			